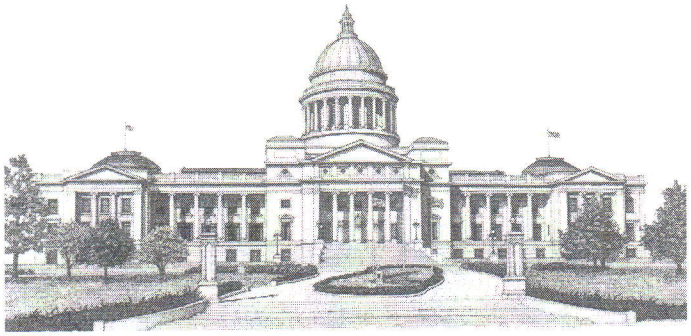
ARKANSAS REGISTER



Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
Mark Martin
500 Woodlane, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Cathy Coffman E-mail cathy.coffman@dhs.arkansas.gov Phone 501-537-1670

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: Notice of Rule Making 2016 CPT and HCPCS Code Conversion Notices

Intended Effective Date
(Check One)

- ☐ Emergency (ACA 25-15-204)
- ☑ 10 Days After Filing (ACA 25-15-204)
- ☐ Other _____ (Must be more than 10 days after filing date.)

	Date
Legal Notice Published	08/22/16-08/24/16
Final Date for Public Comment	09/20/16
Reviewed by Legislative Council	12/16/16
Adopted by State Agency	12/28/16

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Becky Murphy — becky.murphy@dhs.arkansas.gov

Contact Person — E-mail Address — Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Dawn Stehle /TDH
Signature

(501) 683-4997 — dawn.stehle@dhs.arkansas.gov
Phone Number — E-mail Address

Director
Title

12/19/16
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE NO. 501-537-2064 **FAX NO.** 501-404-4619 **EMAIL:** Brian Jones @dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Notice of Rulemaking 2016 CPT and 2016 HCPCS 2016 code conversion

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	$ 56,512	General Revenue	$ 68,016
Federal Funds	$130,427	Federal Funds	$156,311
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$186,939	Total	$224,327

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity (ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ 56,512

Next Fiscal Year
$ 68,016

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

REQUEST FOR MOLECULAR PATHOLOGY LABORATORY SERVICES

Arkansas Foundation for Medical Care, Inc.
Attn: Molecular Pathology Review
P O Box 180001
Fort Smith, AR 72918-0001
Fax: (479) 649-9413

DATE: ____/____/____

Important: If all required information is not completed, the form will be returned to the provider.

(1) **PERFORMING PROVIDER NAME**	(2) **PROVIDER ID#/TAXONOMY CODE**
(3) **MAILING ADDRESS**	(4) **GROUP PROVIDER ID #** (9 digits) __ __ __ __ __ __ __ __ __
CITY **STATE** **ZIP CODE**	
(5) **PERFORMING PROVIDER SIGNATURE & CREDENTIALS**	

(6) **BENEFICIARY NAME [LAST]** **[FIRST]** **[M.I.]**	
(7) **ADDRESS** **CITY** **STATE** **ZIP CODE**	
(8) **MEDICAID BENEFICIARY ID** (10 digits) __ __ __ __ __ __ __ __ __ __	(9) **DOB MM/DD/YY** ____/____/_____ **SEX** _____

To file a Request for Molecular Pathology Laboratory Services, the following information is required:

							Request Disposition *Completed By AFMC*		
(10) SERVICE FROM DATE	(11) SERVICE TO DATE	(12) DIAGNOSIS CODE	(13) DIAGNOSIS CODE DESCRIPTION	(14) PROCEDURE CODE	(15) PROCEDURE CODE DESCRIPTION	(16) UNITS	**DECISION**		**DATE OF REVIEW**
							APPROVED	**DENIED**	

Molecular Pathology Request # _____
Completed by AFMC

Note: If applicable, attach copies of Medical Records/Supporting Documentation substantiating the medical necessity of requested services/procedures.
[Instructions for requesting molecular pathology and completion of this form are included on the reverse side of this form.]
Comments:

Requirements for Requests for Molecular Pathology Laboratory Services

Procedural Policy

To reduce delays in processing requests and to avoid returning requests due to incomplete and/or lack of documentation, the following procedures must be followed.

I. Requests for molecular pathology laboratory services must be requested and a prior authorization received prior to billing the claims.

II. The Request for Molecular Pathology Laboratory Services (Form DMS-841) must accompany the supporting clinical record when submitting a paper request.

III. Molecular Pathology Laboratory Services requests will be denied if received after the timely filing time frame (12 months beyond the date of service).

IV. AFMC Molecular Pathology Laboratory requests will be considered if all of the following documentation is received with the request.

A. All fields of form DMS-841 must be correctly completed by entering the following information:

(1) Enter performing provider's name.
(2) Enter the provider ID # and taxonomy code of performing provider.
(3) Enter the address the provider will use to receive correspondence regarding this request.
(4) If the provider is a member of a group, enter the group provider ID #.
(5) Performing provider's signature and credentials must be entered in this field.
(6) Enter the beneficiary's full name.
(7) Enter the beneficiary's complete address.
(8) Enter the beneficiary's Medicaid ID #.
(9) Enter the beneficiary's date of birth and sex.
(10) Enter the service from date.
(11) Enter the service to date.
(12) Enter the diagnosis code.
(13) Enter the diagnosis code description.
(14) Enter the procedure code and applicable modifier(s). (If there are more than 8 procedures, additional procedures must be added to a separate, completed form.)
(15) Enter the procedure code description.
(16) Enter the number of units.

B. Clinical records must:

1. Be legible and include records supporting the specific request.
2. Be signed by the performing provider.

C. Laboratory reports must include:

1. Clinical indication for lab
2. Signed orders for laboratory

D. Requests for reconsideration must be received within 30 calendar days of AFMC denial - only one reconsideration will be allowed.

E. AFMC reserves the right to request further clinical documentation as deemed necessary to complete a medical review.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

REVISED NOTICE OF RULE MAKING

TO: **Health Care Providers – All Providers**

DATE: **August 26, 2016**

SUBJECT: **2016 Current Procedural Terminology (CPT®) Code Conversion**

I. General Information

A review of the 2016 Current Procedural Terminology (CPT®) procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting CPT® 2016 procedure codes for dates of service on and after August 26, 2016.

Procedure codes that are identified as deletions in CPT® 2016 (Appendix B) are **non-payable** for dates of service on and after August 26, 2016.

For the benefit of those programs impacted by the conversions, the Arkansas Medicaid website fee schedules will be updated soon after the implementation of the 2016 CPT® and Healthcare Common Procedure Coding System Level II (HCPCS) conversions.

II. Process for Obtaining Prior Authorization

When obtaining a Prior Authorization (PA) from the Arkansas Foundation for Medical Care (AFMC), please send your request to the following:

In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax	(479) 649-0799
Web portal	https://afmc.org/review/iexchange/
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	5111 Rogers Avenue, Suite 476 Fort Smith, AR 72903
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

III. Non-Covered 2016 CPT® Procedure Codes

A. Effective for dates of service on and after August 26, 2016, the following CPT® procedure codes are non-covered:

43210	50705	61645	61650	61651	65785	77767	77768
78265	78266	81219	81273	81311	81490	81493	81525
81528	81535	81536	81538	81540	81545	90625	90697
93050	96931	96932	96933	96934	96935	93636	99177

B. All 2016 CPT® procedure codes listed in **Category II** (supplemental tracking for performance codes) and **Category III** (a set of temporary codes for emerging technology) are not recognized by Arkansas Medicaid; therefore, they are non-covered.

C. The following new 2016 CPT® procedure codes are not payable to Outpatient Hospitals because these services are covered by another CPT® procedure code, another HCPCS code or a revenue code:

10036	45742	47543	47544	50606	50706	64462

IV. CPT® Lab and Molecular Pathology Procedure Codes

Molecular Pathology procedure codes in this section listed in points A and B below, require Prior Authorization (PA). Providers are to acquire Prior Authorization before a claim for Molecular Pathology is filed for payment. Providers may request the PA from Arkansas Foundation for Medical Care (AFMC) before or after the procedure is performed as long as it is acquired within the 365-day filing deadline. Providers of these procedures may submit Molecular Pathology requests and medical record documentation to AFMC via mail, fax or electronically through a web portal. See additional contact information for AFMC in Section II of this notice.

Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory Services (Form DMS-841) and the attachment of all pertinent clinical documentation needed to justify the procedure. If the request is approved, a Prior Authorization number will be assigned and the provider will receive notification of the approval in writing by mail. If the request does not meet the medical necessity criteria and is denied, the requesting provider will receive notification of the denial in writing by mail. Reconsideration is allowed if new or additional information is received by AFMC within 30 days of the initial denial. A sample copy of Form DMS-841 is attached. This form may be found in Section V of the provider manual. Copies may be made of this form. The enclosed form is for informational purposes only. **Please do not complete the enclosed form unless you are submitting a Molecular Pathology PA request.**

Molecular Pathology procedure codes must be submitted on a redline paper claim form with the PA listed on the claim and the itemized invoice attached that supports the charges for the test billed.

A. The following 2016 CPT® Molecular Pathology codes require a Prior Authorization from the Arkansas Foundation for Medical Care (AFMC):

81162	81170	81218	81272	81276	81314	81412	81422*
81432*	81433*	81434*	81437*	81438*			

*Requires paper claim submission.

B. The following 2016 CPT® Laboratory codes with special coverage criteria include the following:

Procedure Code	Age Restriction in Years	Diagnosis	Special Instructions	Requires Prior Authorization
81412	No	No	Panel testing is only covered when the panel would replace and would be of similar or lower cost than individual gene testing including CF carrier testing.	Yes
81595	No	No	Generic testing for cardiac transplant rejection (CPT 81595) included only for patients at least (1) one year post transplant who are without clinical signs of rejections.	Yes

V. Hearing Providers

The following 2016 CPT® procedure codes are payable to Hearing Providers:

92537	92538

VI. Hospital Providers

The following 2016 CPT® procedure code is payable to Hospital Providers with special instructions:

Procedure Code	Required Modifiers	Age Restriction in Years
49185	No	No

NOTE: Requires paper billing and documentation attached that describes that sclerotherapy of fluid collections is indicated for the treatment of cysts, seromas or lymphoceles which are causing bleeding, infection, severe pain, organ torsion or organ dysfunction.

VII. Independent Radiology Providers

The following 2016 CPT® procedure codes are payable to Independent Radiology Providers:

72081	72082	72083	72084	73501	73502	73503	73521
73522	73523	73551	73552	74712	74713	77770	77771
77772							

Procedure Code	Required Modifiers	Age Restriction in Years
74712	No	No
74713	No	No

NOTE: Fetal MRI is covered when all of the following conditions are met: 1) Abnormalities are found on fetal ultrasound performed by an experienced sonologist which cannot be adequately further evaluated by 2D or 3D ultrasound. 2) The information obtained by fetal MRI is necessary for decisions about fetal or neonatal therapy, delivery planning or to advise a family about prognosis. 3) The fetus is 18 weeks gestational age or older. 4) The MRI is performed and interpreted at a center with technicians and radiologists who are either trained or highly experienced on fetal MRI and which has appropriate MRI equipment.

VIII. Nurse Practitioner

The payment for Laboratory codes listed on the **Nurse Practitioner Fee Schedule** is based on Clinical Laboratory Improvement Amendments (C.L.I.A.) certification. Note that only C.L.I.A.-certified providers may bill for lab procedures performed in the provider's office, place of service 11. Nurse Practitioner Providers that bill C.L.I.A.-required Laboratory procedure codes must have the current C.L.I.A. certification on file with the Arkansas Medicaid Provider Enrollment Unit.

*The **technical** component of Radiology procedure codes listed on the **Nurse Practitioner Fee Schedule** is payable when performed in the office place of service (11) if the Nurse Practitioner Provider owns the equipment. The technical component must be billed on the claim with modifier **TC** added to the procedure code on the claim detail.

Procedure Code	Required Modifiers	Age Restriction in Years
74712	No	No
74713	No	No

NOTE: Fetal MRI is covered when all of the following conditions are met: 1) Abnormalities are found on fetal ultrasound performed by an experienced sonologist which cannot be adequately further evaluated by 2D or 3D ultrasound. 2) The information obtained by fetal MRI is necessary for decisions about fetal or neonatal therapy, delivery planning or to advise a family about prognosis. 3) The fetus is 18 weeks gestational age or older. 4) The MRI is performed and interpreted at a center with technicians and radiologists who are either trained or highly experienced on fetal MRI and which has appropriate MRI equipment.

The following 2016 CPT® procedure codes are payable to Nurse Practitioner Providers:

69209	72081	72082	72083	72084	73501	73502	73503
73521	73522	73523	73551	73552	74712	74713	77770
77771	77772	80081	81162	81170	81218	81272	81276
81412	81432	81433	81434	81437	81438	81442	88350
99188							

IX. Oral Surgeons

The following 2016 CPT® procedure codes are payable to Oral Surgeon Providers:

99415	99416

X. Physicians

The 2016 CPT® procedure code **33477** is payable to Physicians with Prior Authorization from the Arkansas Foundation for Medical Care (AFMC).

XI. Miscellaneous Information

A. Effective for dates of service on or after August 26, 2016 – sterilization procedure **58565** (hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) and the supply of the implant will no longer be covered by Arkansas Medicaid for any provider program.

B. Existing CPT® procedure codes **43775 and 43843** are now payable to Physicians:

Procedure Code	Required Modifiers	Age Restriction in Years	Special Instructions
43775	No	18y - 64y	Requires Prior Authorization
43843	No	18y - 64y	Requires Prior Authorization

C. Existing CPT® procedure code **99188** is now payable to Physicians and Nurse Practitioners:

Procedure Code	Required Modifier	Age Restriction in Years
99188	No	0 - 20y

NOTE: Dental prophylaxis and a fluoride treatment are preventive treatments covered by Medicaid. Prophylaxis, in addition to application of topical fluoride and/or fluoride varnish, is covered every six (6) months plus one (1) day for beneficiaries under age 21. As a result of Act 90 of 2011, Arkansas physicians, nurses and other licensed health care professionals, as well as dentists, dental hygienists and dental assistants, can apply fluoride varnish. Arkansas Medicaid covers fluoride varnish application performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health. Eligible physicians may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. Physicians and nurse practitioners must complete training on dental caries risk and have an approved fluoride varnish certification from the Arkansas Department of Health, Office of Oral Health. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate to HPE Provider Enrollment. The course that meets the requirements outlined by Act 90 of 2011 can be accessed at http://ar.train.org. If further treatment is needed due to severe periodontal problems, the provider must request Prior Authorization with a brief narrative.

Dental Providers must follow the Dental Program Manual for policy related to this service.

D. Existing CPT® procedure code **77387** is now payable to Nurse Practitioner, Physician, Hospital and Independent Radiology Providers.

E. Diagnosis code **Z51.89** is a payable ICD-10 diagnosis and should be used according to ICD protocols.

If you have questions regarding this notice, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for download from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

REVISED NOTICE OF RULE MAKING

TO: **Health Care Providers – All Providers**

DATE: **August 26, 2016**

SUBJECT: **2016 Healthcare Common Procedure Coding System Level II (HCPCS) Code Conversion and Code on Dental Procedures and Nomenclature (CDT) Conversion**

I. General Information

A review of the 2016 HCPCS procedure codes has been completed and the Arkansas Medicaid Program will begin accepting updated Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes on claims with dates of service on and after August 26, 2016. Drug procedure codes require National Drug Code (NDC) billing protocol. Drug procedure codes that represent radiopharmaceuticals, vaccines and allergen immunotherapy are exempt from the NDC billing protocol.

Procedure codes that are identified as deletions in 2016 HCPCS Level II and 2016 Current Dental Terminology (CDT) will become non-payable for dates of service on and after August 26, 2016.

Please NOTE: The Arkansas Medicaid website fee schedules will be updated soon after the implementation of the 2016 CPT and HCPCS conversions.

II. 2016 HCPCS Payable Procedure Codes Tables Information

Procedure codes are in separate tables. Tables are created for each affected provider type (i.e., Prosthetics, Home Health, etc.).

The tables of payable procedure codes for all affected programs are designed with seven columns of information. All columns may not be applicable for each covered program, but are devised for ease of reference.

Please NOTE: An asterisk indicates that the procedure code requires a paper claim.

1. The **first** column of the list contains the HCPCS procedure codes. The procedure code may be on multiple lines on the table, depending on the applicable modifier(s) based on the service performed.
2. The **second** column indicates any modifiers that must be used in conjunction with the procedure code, when billed, either electronically or on paper.
3. The **third** column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years.
4. Certain procedure codes are covered only when the primary diagnosis is covered within a specific ICD diagnosis range. This information is used, for example, by physicians and hospitals. The **fourth** column, for all affected programs, indicates the

beginning and ending range of ICD CM diagnoses for which a procedure code may be used.

5. The **fifth** column contains information about the diagnosis list for which a procedure code may be used. (See Section IV of this notice for more information about diagnosis range and lists.)
6. The **sixth** column indicates whether a procedure is subject to medical review before payment. The column is titled "Review." The word "Yes" or "No" in the column indicates whether a review is necessary or not. Providers should consult their program manual to obtain the information that is needed for a review.
7. The **seventh** column shows procedure codes that require Prior Authorization (PA) before the service may be provided. The column is titled "PA." The word "Yes" or "No" in the column indicates if a procedure code requires Prior Authorization. Providers should consult their program manual to ascertain what information should be provided for the Prior Authorization process.

III. A. Process for Obtaining a Prior Authorization Number from Arkansas Foundation for Medical Care (AFMC)

In collaboration with AFMC, DMS is changing the process for acquiring prior approval for drug procedure codes from a prior approval letter to a Prior Authorization number (PA). Instead of attaching a prior approval letter to a paper claim, providers will now list the Prior Authorization number on the claim. This will mean that effective for claims submitted on and after August 26, 2016, drug procedure codes requiring Prior Authorization should be billed with the PA number listed on the claim form. These drugs may be billed electronically or on a paper claim. Additionally, these procedure codes requiring a PA will no longer require manual review during the processing of the claim.

As part of the transition, AFMC will send a letter to all providers who have approval letters spanning timeframes within the last 365 days at the time of the effective date of this policy. The letter will contain a Prior Authorization number and the total remaining number of the approved units that can be billed. Any providers who have questions regarding Prior Authorization numbers and/or the transition process outlined above can contact AFMC at the following:

Toll Free: 1-877-350-2362, ext. 8741 or (501) 212-8741

A Prior Authorization number (PA) must be requested before treatment is initiated for any drug, therapeutic agent or treatment that indicates a Prior Authorization is required in a provider manual or an official Division of Medical Services correspondence.

The Prior Authorization requests should be completed using the approved AFMC Prior Authorization request form and must be submitted by mail, fax or *iexchange* at (**https://afmc.org/review/iexchange/**). **(View or print PA form.)**

A decision letter will be returned to the provider by fax or *iexchange* within five (5) business days.

If approved, the Prior Authorization number must be appended to all applicable claims, within the scope of the approval and may be billed electronically or on a paper claim with additional documentation when necessary. Claims billed on paper will be subject to a 30 day hold of the adjudicated payment.

Denials will be subject to reconsideration if received by AFMC with additional documentation within fifteen (15) business days of date of denial letter.

A reconsideration decision will be returned within five (5) business days of receipt of the reconsideration request.

B. Contact Information for Obtaining Prior Authorization

When obtaining a Prior Authorization from the Arkansas Foundation for Medical Care, please send your request to the following:

In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax – General	(479) 649-0799
Fax – Physician Drug Reviews Only (PDR)	(501) 212-8663
Web portal	https://afmc.org/review/iexchange/
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	5111 Rogers Avenue, Suite 476 Fort Smith, AR 72903
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

IV. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), Diagnosis Range and Diagnosis Lists

Diagnosis is documented using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). Certain procedure codes are covered only for a specific primary diagnosis or a particular diagnosis range. **Diagnosis list 103** is specified here (**View ICD Codes.**). For any other diagnosis restrictions, reference the table for each individual program.

V. HCPCS Procedure Codes Payable to Certified Nurse Midwife Providers

The following information is related to procedure codes payable to Certified Nurse Midwife providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0695	No	18y & up	No	No	No	No
J2547	No	18y & up	View ICD Codes.	No	No	No
J7297*	FP	12y–65y	No	No	No	No
NOTE: J7297 with an FP modifier requires a primary diagnosis of family planning on the claim.						
J7298*	FP	12y–65y	No	No	No	No
NOTE: J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.						

*For females only

VI. Dental

A. The following 2016 American Dental Association (ADA) Dental procedure codes **are not covered** by Arkansas Medicaid:

D0251	D0422	D0423	D1354	D4283	D4285	D5221	D5222
D5223	D5224	D7881	D8681	D9243	D9932	D9933	D9934
D9935	D9943						

B. American Dental Association procedure code **D0190** is payable to dentists and oral surgeons. **D0190 is NOT payable with D0120, D0140, D1206, D1208** or **D1120** when billed on the same date of service or within 180 days.

C. American Dental Association procedure code **D9223** is payable to oral surgeons and dentists for ages 0y-20y with Prior Authorization. **D9223** replaces 2016 deleted codes **D9221** and **D9222.**

VII. HCPCS Procedure Codes Payable to End-Stage Renal Disease Providers

The following information is related to procedure codes payable to End-Stage Renal Disease providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1443	No	No	No	No	No	Yes

VIII. HCPCS Procedure Codes Payable to Federally Qualified Health Centers (FQHC)

The following information is related to procedure codes payable to Federally Qualified Health Center providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7297*	FP	12y–65y	No	No	No	No
NOTE:	J7297 with an FP modifier requires a primary diagnosis of family planning on the claim.					
J7298*	FP	12y–65y	No	No	No	No
NOTE:	J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.					

*For females only

IX. HCPCS Procedure Codes Payable to Home Health Providers

The following information is related to procedure codes payable to Home Health providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
A4337	NU EP	No	No	No	No	No
T4525*	NU	3y & up	No	No	No	No

*Existing code being made payable in 2016. The description for **T4525 NU** is as follows:
Adult-sized disposable incontinent product, protective underwear/pull-on, small sized, each.

X. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes payable to Hospital providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
C9460	No	18y & up	No	No	No	No
NOTE:	Kengreal is a $P2Y_{12}$ platelet inhibitor indicated as an adjunct to percutaneous coronary intervention (PCI) for reducing the risk of periprocedure myocardial infarction (MI), repeat coronary revascularization, and stent thrombosis (ST) in patients who have not been treated with a $P2Y_{12}$ platelet inhibitor and are not being given a glycoprotein IIB/IIIA inhibitor.					
J0202	No	No	No	No	No	Yes
J0596	No	13y & up	View ICD Codes.	No	Yes	No
J0695	No	18y & up	No	No	No	No
J0714	No	18y & up	No	No	No	No
J0875	No	18y & up	No	No	No	No
J1443	No	No	No	No	No	Yes
J1447	No	No	No	No	No	Yes
J1575	No	18y & up	No	No	Yes	No
J1833	No	18y & up	No	No	No	No
J2407	No	18y & up	No	No	No	No
J2502	No	No	No	No	No	Yes
J2547	No	18y & up	View ICD Codes.	No	No	No
J2860	No	No	No	No	No	Yes
J3090	No	18y & up	No	No	No	No
J3380	No	18y–99y	No	No	No	Yes
J7121	No	No	No	No	No	No
J7188	No	No	No	No	No	Yes
J7205	No	No	No	No	No	Yes
J7297*	No	12y–65y	No	No	No	No
NOTE:	J7297 requires a primary diagnosis of family planning when administered for this purpose.					
J7298*	No	12y–65y	No	View ICD Codes.	No	No

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7298*	No	12y–65y	No	No	No	No
NOTE:	J7298 requires a primary diagnosis of family planning when administered for this purpose.					
J7313	No	No	No	No	No	Yes
J7328	No	No	No	No	No	Yes
J9032	No	No	No	No	No	Yes
J9039	No	No	No	No	No	Yes
J9271	No	No	No	No	No	Yes
J9299	No	No	No	No	No	Yes
J9308	No	No	No	No	No	Yes
Q5101	No	No	No	No	No	Yes
Q9980	No	No	No	No	No	Yes

*For females only

XI. HCPCS Procedure Codes Payable to Nurse Practitioners

The following information is related to procedure codes payable to Nurse Practitioner providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
C9460	No	18y & up	No	No	No	No
NOTE:	Kengreal is a $P2Y_{12}$ platelet inhibitor indicated as an adjunct to percutaneous coronary intervention (PCI) for reducing the risk of periprocedure myocardial infarction (MI), repeat coronary revascularization, and stent thrombosis (ST) in patients who have not been treated with a $P2Y_{12}$ platelet inhibitor and are not being given a glycoprotein IIB/IIIA inhibitor.					
J0202	No	No	No	No	No	Yes
J0596	No	13y & up	View ICD Codes.	No	Yes	No
J0695	No	18y & up	No	No	No	No
J0714	No	18y & up	No	No	No	No
J0875	No	18y & up	No	No	No	No
J1443	No	No	No	No	No	Yes

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1447	No	No	No	No	No	Yes
J1575	No	18y & up	No	No	Yes	No
J1833	No	18y & up	No	No	No	No
J2407	No	18y & up	No	No	No	No
J2502	No	No	No	No	No	Yes
J2547	No	18y & up	View ICD Codes.	No	No	No
J2860	No	No	No	No	No	Yes
J3090	No	18y & up	No	No	No	No
J3380	No	18y–99y	No	No	No	Yes
J7121	No	No	No	No	No	No
J7188	No	No	No	No	No	Yes
J7205	No	No	No	No	No	Yes
J7297*	FP	12y–65y	No	No	No	No
NOTE:	J7297 with an FP modifier requires a primary diagnosis of family planning on the claim.					
J7298*	No	12y–65y	No	View ICD Codes.	No	No
J7298*	FP	12y–65y	No	No	No	No
NOTE:	J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.					
J7328	No	No	No	No	No	Yes
J9032	No	No	No	No	No	Yes
J9039	No	No	No	No	No	Yes
J9271	No	No	No	No	No	Yes
J9299	No	No	No	No	No	Yes
J9308	No	No	No	No	No	Yes
Q5101	No	No	No	No	No	Yes
Q9980	No	No	No	No	No	Yes

*For females only

XII. HCPCS Procedure Codes Payable to Physicians and Area Health Education Centers (AHECs)

The following information is related to procedure codes payable to Physician and AHEC providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
C9460	No	18y & up	No	No	No	No
NOTE:	Kengreal is a $P2Y_{12}$ platelet inhibitor indicated as an adjunct to percutaneous coronary intervention (PCI) for reducing the risk of periprocedure myocardial infarction (MI), repeat coronary revascularization, and stent thrombosis (ST) in patients who have not been treated with a $P2Y_{12}$ platelet inhibitor and are not being given a glycoprotein IIB/IIIA inhibitor.					
J0202	No	No	No	No	No	Yes
J0596	No	13y & up	**View ICD Codes.**	No	Yes	No
J0695	No	18y & up	No	No	No	No
J0714	No	18y & up	No	No	No	No
J0875	No	18y & up	No	No	No	No
J1443	No	No	No	No	No	Yes
J1447	No	No	No	No	No	Yes
J1575	No	18y & up	No	No	Yes	No
J1833	No	18y & up	No	No	No	No
J2407	No	18y & up	No	No	No	No
J2502	No	No	No	No	No	Yes
J2547	No	18y & up	**View ICD Codes.**	No	No	No
J2860	No	No	No	No	No	Yes
J3090	No	18y & up	No	No	No	No
J3380	No	18y–99y	No	No	No	Yes
J7121	No	No	No	No	No	No
J7188	No	No	No	No	No	Yes
J7205	No	No	No	No	No	Yes

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7297*	FP	12y–65y	No	No	No	No
NOTE:	J7297 with an FP modifier requires a primary diagnosis of family planning on the claim.					
J7298*	No	12y–65y	No	View ICD Codes.	No	No
J7298*	FP	12y–65y	No	No	No	No
NOTE:	J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.					
J7313	No	No	No	No	No	Yes
J7328	No	No	No	No	No	Yes
J9032	No	No	No	No	No	Yes
J9039	No	No	No	No	No	Yes
J9271	No	No	No	No	No	Yes
J9299	No	No	No	No	No	Yes
Q5101	No	No	No	No	No	Yes
Q9980	No	No	No	No	No	Yes

*For females only

XIII. HCPCS Procedure Codes Payable to Private Duty Nursing Providers

The following information is related to procedure codes payable to Private Duty Nursing providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
A4337	NU EP	No	No	No	No	No

XIV. HCPCS Procedure Codes Payable to Prosthetics Providers

The following information is related to procedure codes payable to Prosthetics providers:

Procedure codes in the table must be billed with appropriate modifiers. For procedure codes that require a Prior Authorization, the written PA request must be submitted to the Arkansas Foundation for Medical Care (AFMC) for wheelchairs and wheelchair-related equipment and services.

For other durable medical equipment (DME), a written request must be submitted to the Arkansas Foundation for Medical Care. Please refer to your Arkansas Medicaid Prosthetics Provider Manual for details on requesting a DME Prior Authorization.

Procedure Code	Modifier	Diagnosis	Diagnosis List	Review	PA
A4337	NU EP	No	No	No	No
E1012	NU EP	No	No	No	Yes
T4525*	NU	No	No	No	No

*Existing code being made payable in 2016. The description for **T4525 NU** is as follows: Adult-sized disposable incontinent product, protective underwear/pull-on, small sized, each.

XV. HCPCS Procedure Codes Payable to Ventilator Providers

The following information is related to procedure codes payable to Ventilator providers:

⁂(…)This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

2016 Replacement Code	Modifier	2016 Deleted Code	Description	PA	Maximum Units	Payment Method
E0465	No	E0450	Home Ventilator, any type, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Rental Only
E0465	UB	E0450 UB	⁂(Ventilator supplies – Includes suction catheter kits, trach kits, trach tubes, sterile water and all respiratory care supplies.) Home Ventilator, any type, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Purchase
E0465	U1	E0450 U1	⁂(Used equipment) Home Ventilator, any type, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Rental Only
E0465	No	E0463	Home Ventilator, any type, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Rental Only
E0465	UB	E0463 UB	⁂(Ventilator supplies – Includes suction catheter kits, trach kits, trach tubes, sterile water and all respiratory care supplies.) Home Ventilator, any type, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Purchase
E0466	U1	E0460 U1	⁂Negative pressure ventilator; portable or stationary	Yes	1 per day (1 day = 1 unit)	Rental Only

2016 Replacement Code	Modifier	2016 Deleted Code	Description	PA	Maximum Units	Payment Method
E0466	No	E0463	Home Ventilator, any type, used with non-invasive interface (e.g., mask, chest shell)	Yes	1 per day (1 day = 1 unit)	Rental Only

XVI. Miscellaneous Information

A. Existing HCPCS procedure code **T4525 NU** is being made payable in 2016 for Prosthetic and Home Health providers. The description for **T4525 NU** is as follows:

Adult-sized disposable incontinent product, protective underwear/pull-on, small sized, each.

B. **L1902, L1904** and **L8621** have national new descriptions in HCPCS 2016.

C. HCPCS procedure code **C9349** is an existing code, whose description was changed in 2016. Effective on or before dates of service August 26, 2016, **C9349** will not be covered by Arkansas Medicaid.

D. The description for existing HCPCS procedure code **K0017** has been changed to the national description. Procedure codes **K0017** and **K0018** are existing codes, but the description and utilization of the codes have changed.

E. The following table represents updates in the Prosthetics Manual:

Procedure Code	Modifier	Description	PA	Maximum Units	Payment Method
K0017	NU EP	Detachable , adjustable height armrest, base, replacement only	No	2	Purchase
K0018	NU EP	Detachable , adjustable height armrest, upper portion, replacement only	No	2	Purchase
L1902	NU EP	Ankle orthosis, ankle gauntlet or similar, with or without joints, prefabricated ,off the shelf	No	2	Purchase
L1904	NU EP	Ankle orthosis, ankle gauntlet or similar, with or without joints, custom fabricated	No	2	Purchase

Procedure Code	Modifier	Description	PA	Maximum Units	Payment Method
L8621	EP	Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement each	Yes	180 units per 6 months (360)	

E. The following table of existing HCPCS codes are covered and require a Prior Authorization from AFMC.

Procedure Code	Procedure Code	Procedure Code	Procedure Code	Procedure Code	Procedure Code	Procedure Code
C9257	J0129	J0178	J0180	J0220	J0221	J0490
J0641	J0717	J0894	J0897	J1458	J1556	J1602
J1743	J1745	J1756	J1786	J1931	J2323	J2353
J2354	J2507	J2778	J3060	J3262	J3357	J3385
J7310	J7312	J7316	J7321	J7323	J7324	J7325
J7327	J9019	J9025	J9033	J9035	J9041	J9042
J9043	J9047	J9055	J9160	J9178	J9179	J9207
J9226	J9228	J9261	J9262	J9263	J9264	J9301
J9302	J9303	J9305	J9306	J9307	J9328	J9354
J9371	J9395	J9400	Q2043			

F. Diagnosis code **Z51.89** is a payable ICD-10 diagnosis and should be used according to ICD protocols.

XVII. Non-Covered HCPCS Procedure Codes

The following 2016 HCPCS procedure codes **are not covered** by Arkansas Medicaid:

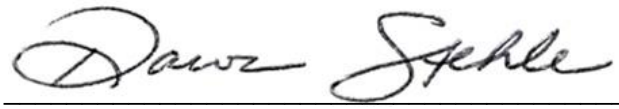
C1822	C2613	C2623	C2645	C9349	C9458	C4959
C9743	G0296	G0297	G0300	G0475	G0476	G0477
G0478	G0479	G0480	G0481	G0482	G0483	G9473
G9474	G9475	G9476	G9477	G9478	G9479	G9480
G9496	G9497	G9498	G9499	G9500	G9501	G9502
G9503	G9504	G9505	G9506	G9507	G9508	G9509
G9510	G9511	G9512	G9513	G9514	G9515	G9516
G9517	G9518	G9519	G9520	G9521	G9522	G9523
G9524	G9525	G9526	G9529	G9530	G9531	G9532
G9533	G9534	G9535	G9536	G9537	G9538	G9539
G9540	G9541	G9542	G9543	G9544	G9547	G9548
G9549	G9550	G9551	G9552	G9553	G9554	G9555
G9556	G9557	G9558	G9559	G9560	G9561	G9562
G9563	G9572	G9573	G9574	G9577	G9578	G9579
G9580	G9581	G9582	G9583	G9584	G9585	G9593
G9594	G9595	G9596	G9597	G9598	G9599	G9600
G9601	G9602	G9603	G9604	G9605	G9606	G9607
G9608	G9609	G9610	G9611	G9612	G6913	G9614
G9615	G9616	G6917	G9618	G9619	G9620	G9621
G9622	G9623	G9624	G9625	G9626	G9627	G9628
G9629	G9630	G9631	G9632	G9633	G9634	G9635
G9636	G9637	G9638	G9639	G9640	G9641	G9642
G9643	G9644	G9645	G9646	G9647	G9648	G9649
G9650	G9651	G9652	G9653	G9654	G9655	G9656
G9657	G9658	G9659	G9660	G9661	G9662	G9663
G9664	G9665	G9666	G9667	G9669	G9670	G9671
G9672	G9673	G9674	G9675	G9676	G9677	J7340
J7503	J7512	J7999	J8655	L8607	P9070	P7091
P9072	Q4161	Q4162	Q4163	Q4164	Q4165	Q9950

If you have questions regarding this notice, please contact the Hewlett Packard Enterprise Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for download from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.



Dawn Stehle
Director